NOTE Patients who don't have to pay must fill in parts 1 and 3. Those who pay must fill in parts 2 and 3. Penalty charges may be applied if you make a wrongful claim for free prescriptions. If you're not sure about getting free prescriptions, pay and ask for an NHS receipt FP57. You can't get one later. The FP57 tells you about getting a refund.

Part 1 The patient doesn't have to pay because he/she

A	☐	is under 16 years of age
B	☐	is 16, 17 or 18 and in full-time education
C	☐	is 60 years of age or over
D	☐	has a valid maternity exemption certificate
E	☐	has a valid medical exemption certificate
F	☐	has a valid prescription pre-payment certificate
G	☐	has a valid War Pension exemption certificate
L	☐	is named on a current HC2 charges certificate
X	☐	was prescribed free-of-charge contraceptives
H	☐	*gets Income Support (IS)
K	☐	*gets **income based** Jobseeker's Allowance (JSA (IB))
M	☐	*is named on a valid NHS Tax Credit Exemption Certificate
S	☐	*has a partner who gets Minimum Income Guarantee (MIG)

*Name:	Date of Birth:	NI no:

****Print** the name of the person (either you or your partner) who gets IS, JSA (IB), MIG or Tax Credit*

Declaration *For patients who do not have to pay*

I declare that the information that I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by the Primary Care Trust, the Prescription Pricing Authority, the NHS Counter Fraud and Security Management Service, the Department for Work and Pensions and Local Authorities.

Now fill in and sign Part 3

Part 2 I have paid £ Now fill in and sign Part 3

Part 3 *Cross ONE box* I am the patient ☐ patient's representative ☐

Sign Here @ Date

Print name and address *if different from overleaf*

Postcode

PROTOCOL FOR THE SUPPLY AND ADMINISTRATION OF TRIMETHOPRIM FOR UNCOMPLICATED UTI

Pharmacy Stamp	GP Name & Address
Client's Name:	
Consultation Date:	
Date of Birth:	
Address:	
Post Code:	

CLIENT'S HISTORY

Criteria for Inclusion	Yes	No
1. Women aged 16 or over presenting with symptoms associated with an uncomplicated urinary tract infection, namely frequency, dysuria and urgency of recent onset.		

continued overleaf

Criteria for Referral (Exclusion)	Yes	No	Notes
• Child less than 16 years of age			
• Men			
• Pregnancy, possibility of being pregnant or breastfeeding mothers			
• Patients presenting with fever, chills, nausea/vomiting, loin or abdominal pain/tenderness			
• Renal impairment			
• Blood dyscrasias			
• Hypersensitivity to Trimethoprim • Treatment with Trimethoprim for past UTI on 2 or more occasions in past 6 months • Any patient with history of recurrent UTI			
• Patients with actual or potential folate deficiency			
• Porphyria • Haematuria (unless menstruating)			
• Patients taking Pyrimethamine (in Fansidar and Maloprim), Ciclosporin, Azathioprine, Mercaptopurine, Methotrexate and Cytotoxic medication			
• Patients taking Phenytoin, Digoxin or Warfarin			
• Patients already taking a prescribed antibiotic			

Other Relevant Notes:

Please Record:

- The symptoms patient presented with
  ….. … … … … … … .
- Where the client heard about the scheme?
  … … … … … … … … … … … … … …
- Patients consent for notes to go to GP? Yes/ No
- Sent Notification to GP? Via Patient/Post/No
- Advise patient to report to Pharmacist/GP any adverse reactions?
  Yes/No
- NHS levy declaration completed overleaf? Yes/No

Action Taken:

Urine dipstick test (if possible to exclude haematuria): No Yes Result:

Supply:

Batch Number / Expiry Date of Trimethoprim Supplied:
Leaflet PGD03 given: Yes/No

Referral:

Advice Given:

The above information is correct to the best of my knowledge. I have been counselled on the use of Trimethoprim and understand the advice given to me by the pharmacist. I give permission for a copy of these notes to go to my GP.

Client's Signature: … … … … … … … … … … … … … … … … … … … Date: … … … … … ..

The action specified was based on the information given to me by the client, which, to the best of my knowledge, is correct.

Pharmacist's Signature: … … … … … … … … … … … … … … … … … . Date: … … … … … .

Time taken to complete consultation … … … … … … … … … . Minutes.

This PGD is to be reviewed after one year, after audit, please ensure all the protocol is filled in, and the patient is aware of reporting adverse reactions.